DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Neurodevelopmental Centers
Managed Care Plans

Memorandum No: 03-80 MAA
Issued: September 29, 2003

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Neurodevelopmental Centers: HIPAA Changes

Effective for dates of service on and after October 1, 2003, the Medical Assistance Administration (MAA) will **discontinue** state-unique procedure code 0002M.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is **discontinuing all state-unique procedure codes** and will require the use of applicable Current Procedural Terminology (CPT)™ and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Effective for dates of service on and after October 1, 2003, providers may no longer bill for splints using state-unique procedure code 0002M. Attached are updated replacement pages 13/14 and 17/18 for MAA's Neurodevelopmental Centers Billing Instructions, dated September 2000, that reflect this change.

Occupational therapists or physical therapists who wish to dispense splints from their office must apply for a Prosthetics and Orthotics (P&O) provider number. You may apply for a P&O provider number by going to MAA's website at the following link: http://maa.dshs.wa.gov/ProvRel/Index.html or by contacting Provider Enrollment toll-free at (866) 545-0544.

HCFA-1500 Claim Form Instructions

MAA has also updated its HCFA-1500 claim form instructions to reflect changes due to HIPAA implementation. Attached are updated replacement pages 29-32, and 35-40 for MAA's Neurodevelopmental Centers Billing Instructions, dated September 2000, that reflect these changes.

To obtain this document electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

PHYSICAL THERAPY (cont.)

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tests and Measurements			
97001	Pt evaluation	$44.82	$38.45
97002	Pt re-evaluation	24.12	19.34
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97703	Prosthetic checkout	13.65	
97750	Physical performance test	17.52	
Other Procedures			
~~0002M*~~	***Discontinued for dates of service on and after October 1, 2003.***		
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

*State-unique code

TEAM CONFERENCES

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
99361	Physician/team conference	$40.49	$27.98
99362	Physician/team conference	71.89	55.74

PEDIATRIC EVALUATION

Procedure Code/ Modifier	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
New Patient			
99201	Office/outpatient visit, new	$33.48	$22.08
99202	Office/outpatient visit, new	60.20	44.17
99203	Office/outpatient visit, new	89.76	67.32
99204	Office/outpatient visit, new	127.52	99.74
99205	Office/outpatient visit, new	162.07	132.86
Established Patient			
99211	Office/outpatient visit, est	19.95	8.55
99212	Office/outpatient visit, est	35.62	22.44
99213	Office/outpatient visit, est	49.16	33.13
99214	Office/outpatient visit, est	77.30	54.50
99215	Office/outpatient visit, est	113.27	87.98

☞ **Note: Modifier 1C is discontinued. Use modifier HA** with CPT codes 99201-99215 to receive higher reimbursement for these services when using the parent's PIC to bill for services for an infant who has not received his or her own PIC.

Modifier HA: Child/adolescent program

SPEECH THERAPY (cont.)

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Audiologists Only (cont.)			
92601	Cochlear implt f/up exam < 7	$81.67	$81.67
92602	Reprogram cochlear implt < 7	57.10	57.10
92603	Cochlear implt f/up exam 7 >	54.83	54.83
92604	Reprogram cochlear implt 7 >	37.31	37.31
Speech-Language Pathologist Only			
92526	Oral function therapy	50.05	17.52
92597	Oral speech device eval	65.52	43.68
92605	Eval for nonspeech device rx	Bundled	
92606	Non-speech device service	Bundled	
92607	Ex for speech device rx, 1 hr	68.02	68.02
92608	Ex for speech device rx, addl	13.42	13.42
92609	Use of speech device service	36.86	36.86
92610	Evaluate swallowing function	26.16	26.16

Continued on next page…

OCCUPATIONAL THERAPY

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
64550	Apply neurostimulator	$17.06	$5.46
97003	OT evaluation	48.00	37.31
97110	Therapeutic exercises	17.06	17.06
97112	Neuromuscular reeducation	17.52	17.52
97504	Orthotic training	17.29	17.29
97520	Prosthetic training	16.84	16.84
97530	Therapeutic activities	17.29	17.29
97532	Cognitive skills development	14.79	14.79
97533	Sensory integration	15.70	15.70
97535	Self-care mngment training	18.65	18.65
97537	Community/work reintegration	16.61	16.61
97703	Prosthetic checkout	13.65	13.65
~~0002M*~~	***Discontinued for dates of service on and after October 1, 2003***		

*State-unique code

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name. This field ***must*** be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source.)

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: When applicable, enter additional information such as indicator "**B**" to indicate baby on parent's PIC. If the client is one of twins or triplets, enter **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C, " as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403).

24B. **Place of Service**: Required. Enter **11** (office).

24C. **Type of Service**: No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCs) procedure code from the fee schedule in these billing instructions for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070199BROWNA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN MARY J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 99 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 900 NORTH BROADWAY

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 01 03	11		99201		343.9	3348	1				
2 10 01 03	10 01 03	11		97110		343.9	3412	2				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 6760

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 6760

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

NEURO SERVICES
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7105432

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **11** (office).

24C. **Type of Service**: No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Enter appropriate diagnosis code for condition or use V98.0.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days Or Units:** Required. Enter appropriate number of units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

SAMPLE A: MEDICARE COINSURANCE AND SUPPLEMENTAL INSURANCE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): H-041915HANSON

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HANSON HARRY

3. PATIENT'S BIRTH DATE MM 04 DD 19 YY 15 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 16 STUMP ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123 456 789

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA - SUPPLEMENT

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 01 03	11		97003	11.50	343.9	4800	1				40.80
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 4800

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 4800

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

NEURO SERVICES
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

SAMPLE B: MEDICARE DEDUCTIBLE AND COINSURANCE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): R-111231BROWNB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN ROBERT

3. PATIENT'S BIRTH DATE MM DD YY: 11 12 31 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 23 MAINE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	10	01	03	11		97504	5.50	343.9	3458	2				27.46
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 21200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 3458

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 3458

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

NEURO INC
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7654321

PHYSICIAN OR SUPPLIER INFORMATION

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